Telehealth Idaho
Institute of Rural Health
Idaho State University

Comments and Recommendations for the NPRM WC Docket No. 02-60

The Institute of Rural Health is pleased and enthused that the Federal Communications Commission is reviewing the rules related to the use of Universal Service Funds for rural healthcare providers. While this fund offers great potential for our Idaho rural providers, its meager use due to a number of complex factors challenges us to look for ways to make this opportunity real and, thus, to improve access to quality healthcare for our rural citizens. The current process has placed an undue administrative and financial hardship on many of our struggling rural hospitals. Because of its difficulties, they have not been able to receive the financial support necessary for their very existence.

The Institute is the recipient of a telehealth grant from the Office for the Advancement of Telehealth in the Department of Health and Human Services. Staff in the Institute have been involved in a broad range of telehealth activities, both clinical and technological, for over a decade. During that time, we have developed keen insights into the needs of rural healthcare providers and what it takes to operationalize successful programs.

Key Recommendations:

1. Expand the list of eligible providers to include any rural, not-for-profit health care entity with a certified Medicare and/or Medicaid provider number.
2. Include school-based clinics as eligible providers and allow them to access either rural healthcare or school and library subsidies, whichever is more beneficial.

3. Simplify the application process and establish procedures to improve the responsiveness of telecom providers.
4. Allow the rate comparison for a rural provider to be with any city larger than 50,000 within the state, not just the closest city.

Background:

Idaho has unique challenges for healthcare delivery in our rural and frontier areas. The 14th largest U.S. state, it has the 12th smallest population. Its 82,750 square miles have an average population density of 15 people per square mile, five times less than the national average. Forty percent of the state's residents live outside urban areas, on 90% of the state's land. Thirty-five of the 44 total counties have fewer than 25,000 people and 92% of Idaho's towns have populations less than 10,000. A disproportionate number of Idaho rural elders are uninsured or depend on Medicare for their health care services.

In 1998, there were 43 designated primary care shortage areas, covering 93% of the state's counties. HRSA estimates 16% of Idahoans cannot access primary care; the Idaho Department of Health estimates 400,000 primary care visits were needed *beyond* the current capacity. Dental HPSAs cover 73% of the counties and mental health cover 80%. For rural Idahoans, the drive to the nearest tertiary care center averages 80 miles away. In 30 counties, the drive exceeds 100 miles; when mountainous topography and climate are considered, access can be overwhelming. Thus, it is important to support healthcare with distance and climate insensitive methodologies, such as telehealth.

Over half of the hospitals in the state (27 of 44) qualify as Critical Access Hospitals, many of whom suffer financial distress, making it hard to support technology. The technology infrastructure is limited and the "last mile" problem is common. In a survey of the residents in the middle two counties of Idaho[1] 90% (n=1004) of the respondents saw a provider outside of the area; 71% (n=809) made at least one care visit outside of the area; and 45% of households reported someone in the household having been hospitalized outside in the past two years. The most frequently cited reason for seeking care outside of the area (at least 50 mountainous miles distant) was because care was not available locally (75%; n=854). Many older Idahoans move away from their home communities to have better access. In some areas, consumers seem to avoid having children due to access problems.

The isolation of working in rural Idaho creates staff retention problems. Professionals face difficulty obtaining consultations, educational opportunities, and peer networking. It is hard to find coverage for personal and professional leave. Anecdotal evidence suggests workers face burnout and in extreme cases, work-related traumatization (Stamm, 1999).

All of these problems point to the potential value of Universal Service funding support for rural providers. However, Idaho has seen limited use, with 5 providers in Year One, 8 in Year Two, and 4 in Year Three. In interviews with many rural providers who did meet the eligibility criteria, the primary reasons for not accessing the funds were the complexity of the application, the non-responsiveness of the telecom provider, and lack of knowledge of the program and how it could benefit the healthcare provider.

[1] This study is cited as an example, and was completed by Stamm, B. H. 1999. Lemhi And Custer Counties

Comments and Recommendations:

Improve The Responsiveness Of Telecom Providers:

The conclusion that telecommunications carriers must charge eligible rural health care providers a rate that is no higher than the highest tariffed or publicly available commercial rate of a similar service in the closest city in the state with a population of 50,000 or more creates a major disincentive for those companies. There is no need, based on this structure, for the company to add new infrastructure or lower cost services when this level of reimbursement is guaranteed. We recommend that the FCC explore mechanisms to eliminate this disincentive to encourage lower cost opportunities for rural healthcare providers.

Given that many of our rural healthcare providers have encountered difficulty getting applications completed by the telecom company, and that the current procedure guarantees funding to the company regardless of delay, we recommend changes to this procedure. Many Idaho providers give up on the process, in part due to the lack of responsiveness of the telecom provider.

We recommend that:

1. Telecom companies would have a maximum of 90 days to complete and finalize all the forms.
2. During that 90-day period, the telecom company may bill the rural healthcare provider for all applicable charges.
3. After the 90-day period, the telecom company may only bill the healthcare

provider for the discounted amount and must rebate the difference for the first 90 days of service, within 45 days of completion of the RHCD forms.

4. If the telecom company fails to respond in 90 days, they must continue the telecom service and refrain from billing the healthcare provider until such time the forms have been finalized.

Expand Eligible Health Care Providers: The current regulations limit the types of rural healthcare providers eligible for this support. We would recommend that this support be conceptualized as support for rural residents needing healthcare as opposed to specific type of provider. Thus, a critical rural provider, regardless of type, could qualify.

1. We recommend that school-based clinics be approved providers. In some small communities, the school is one of the important public building (if not the only!), and thus is the logical location for a community clinic. These clinics are an important source of physical, mental/behavioral, and oral care for rural citizens, operate in public buildings, and have limited budgets. Their ability to use these funds for telehealth and telemedicine support is critical to their clinical quality and financial viability. We also would recommend that these clinics be allowed to obtain the best discount possible, whether it is the rural health or school and library rate.

2. We recommend that the definition of eligible health care provider be expanded to include any rural, not-for-profit health care entity with a certified Medicare and/or Medicaid provider number.

3. If all rural, not-for-profit health care providers can be included in this

program, then prorating would not be necessary. This would relieve a severe administrative burden on small facilities and make the program more attractive to rural providers.

4. If proration is to occur, it should be done on an event, not time basis.

Include Internet Services: Internet access is an absolutely critical necessity for quality healthcare and access to education and information for rural healthcare providers. Therefore, we support initiatives that would enable the use of Universal Service Funds to support Internet access.

Where the cost of Internet access for similar bandwidth is more expensive in rural areas as opposed to urban areas, discounts should be provided to underwrite access via any modality, including "non-telecom service providers."

Expand the Comparable Urban Area Definition: In Idaho, the Telecommunications Act of 1996 did not trigger significant competition in many areas of the state, especially rural areas. For purposes of discount calculation, we recommend that the rural provider be able to compare their rural rate with any city within the state with a population of over 50,000. There is a greater variety of telecom services and lower rate structure in our larger urban areas of southwest Idaho compared to cities in northern and eastern Idaho. This would be a significant benefit for our providers.

Use Functionality to Define Similar Services: We recommend that similar services be based upon the functionality of the end user as opposed to a specific type of service. Most of rural and frontier Idaho does not have access to DSL or other high speed connections, so functionality and bandwidth equivalency are most important in setting the discounted

rate.

In some parts of Idaho, satellite or other wireless systems are the best and clearest way for our rural providers to connect. We recommend that the discounted rate process should apply to this technology as well as future technologies that provide the same types of function.

Eliminate Maximum Allowable Distances: We support the recommendation to eliminate the Maximum Allowable Distance calculation. It is administratively cumbersome and interferes with the development of telemedicine networks.

Streamline the Application Process: Our experience in Idaho is that almost none of our rural providers have the expertise to complete the current application and receive the discount. Even if they did have the expertise, they would not have sufficient staff time. That in itself says that we need to make this process simpler. As a result, available funds are not accessed and facilities that struggle to keep their doors open are spending money that could be better utilized for patient care. Putting responsibility on the telecom provider to be timely is one way to remedy this situation. Also, where multi-year contracts are in place, there should be a shortened renewal form to use instead of walking through the process from start to finish like a new proposal.

Create an Approved Vendor List: In many parts of Idaho, there is no competition for telecommunications services. We are recommending that telecom providers could be listed on an "approved vendor" list with benchmarked rates identified, similar to the GSA purchasing process. Foreseeably, larger companies would go through the approval process, so there should be a mechanism to either pick off the approved list, or request the approval of an alternate provider. We recognize that using the alternate

telecommunications provider would involve an additional review process. That would make the application and renewal process much easier for our small healthcare providers.

The Universal Service Fund is a critically important resource for Idaho's rural healthcare providers that has not been well used due to its complexity and involvement of multiple parties. We believe that our recommendations will go a long way toward opening this resource in a responsible manner to assure Idaho's rural citizens access to quality healthcare in their own communities.